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IMAGING COUNCIL CHAIRMAN'S PAGE

Imaging at the 2014 ACC Legislative Conference: A Debrief

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The 2014 American College of Cardiology (ACC) Legislative Conference was held in Washington, DC, September 14 to 16. The agenda was intended to provide attendees with information on current regulatory and legislative issues that affect the delivery of cardiovascular care. This paper is a synopsis of 2 imaging-related issues that featured prominently at this 2-day conference:

- the Medicare mandate for appropriate use criteria (AUC) for advanced diagnostic imaging services,
- site-neutral payment policies.

AUC MANDATE

The Protecting Access to Medicare Act of 2014, legislation passed to avert a >20% cut to Medicare physicians' payments, includes a provision directing the Centers for Medicare and Medicaid Services (CMS) to implement a mandate for consultation of AUC for advanced diagnostic imaging services. Beginning in January 2017, Medicare claims for advanced diagnostic imaging services (computed tomography, magnetic resonance, positron emission tomography, nuclear cardiology) will be paid only if the claims include documentation that the physicians ordering the tests consulted AUC. In 2020, CMS must identify up to 5% of physicians as outliers in adherence to AUC, who may then be subject to prior authorization. Key points of the AUC mandate relevant to cardiac imaging include the following:

- Cardiac imaging services affected by the mandate are computed tomography, magnetic resonance, cardiac positron emission tomography, and nuclear cardiology. Echocardiography is excluded.
- The mandate will apply to services performed in both physicians' offices and the hospital outpatient setting, excluding emergency services. Inpatient services are not affected.
- The obligation to document consultation of AUC through a clinical decision support tool falls on the referring physician, but payment is at risk only for the performing physician.
- The initial phase of the program will not result in hard denials for services deemed "rarely appropriate." However, CMS will gather data on referring physicians' patterns of adherence to AUC for purposes of identifying outliers.
- The legislation establishing the AUC mandate provides considerable discretion to CMS for implementing the program. Critical decisions CMS must make include:
  - selection of the specific AUC to be used by November 2015,
  - selection of clinical decision support tools to help referring physicians use AUC at the point of care by April 2016, and
  - definition of the process and parameters for identifying outliers.

CMS will define these program elements through a public rule-making process. The ACC and the imaging subspecialty organizations will be actively engaged in the process to ensure that the program has the greatest chance to contribute to improved patient care while minimizing the burden on providers.

The potential consequences of this AUC mandate for the cardiac imaging community may be unpredictable, and several questions remain. How will implementation of the mandate affect workflow for both referring and performing physicians? How will information flow from referring physicians to imaging laboratories? Also, although surveys have shown significant numbers of inappropriate imaging studies (1), and adherence to AUC has been shown to optimize test performance (2), one of the logistic difficulties is the question of who should be responsible for their implementation in a referral-based environment. For the CMS mandate, the burden of

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implementation falls to referring physicians, but the consequences of nonadherence are mostly for imaging laboratories. One potential result of imposing an onerous mandate on referring physicians for some, but not all, diagnostic testing might simply be a shift in referral patterns, rather than more appropriate use.

For background information on the Protecting Access to Medicare Act and the sustainable growth rate formula, Ferrari et al. (3) provide an excellent review of the evolution of CMS reimbursement systems relevant to cardiovascular imaging.

SITE-NEUTRAL PAYMENT

Another hotly debated item was the Medicare Payment Advisory Commission's (MedPAC) recommendation to CMS for "site neutrality" in payments for services rendered to Medicare patients. Currently, Medicare uses the Hospital Outpatient Prospective Payment System (HOPPS) and the Medicare Physician Fee Schedule (PFS), each with its own distinct methodology for rate setting and for services rendered in the hospital and office settings, respectively (3). Skilled nursing facilities and ambulatory surgical centers also have distinct payment systems. Ferrari et al. (3) provide a review of the current CMS practices for rate-setting for services provided in the different practice environments. In the outpatient setting, Medicare's HOPPS pays higher rates for some services than the PFS does. In other, less prevalent instances, PFS rates exceed HOPPS rates. Policy advisors are increasingly interested in potential savings to the Medicare program from reducing or eliminating such payment differences: site-neutral payment policies.

Conversations around site-neutral payment policies have encompassed the broad range of Medicare payment systems, but cardiology is most affected by proposals to address payment differences between the HOPPS and the PFS. MedPAC, a congressional advisory body, recommended in its March 2014 report that Congress enact "site-neutral" policies that would equalize Medicare HOPPS and PFS payment rates for 66 outpatient service groupings. MedPAC projected an annual savings of $900 million for Medicare and $800 million in reduced beneficiary copayments.

MedPAC's proposal would affect ambulatory payment classifications 269 (Level II echocardiogram without contrast [rest and stress echocardiography without contrast]), 270 (Level III echocardiogram without contrast [rest and stress echocardiography with contrast]), 377 (Level II cardiac imaging [cardiac nuclear studies and cardiac magnetic resonance imaging]), and 383 (cardiac computed tomographic imaging). Under MedPAC's proposal, hospital outpatient payments for services in ambulatory payment classification 269 (Level II echocardiogram without contrast) would be reduced to the payment amount for the corresponding services under the Medicare PFS. Payments for the other 3 ambulatory payment classifications would include additional payments for ancillary services currently packaged into the HOPPS payment but separately payable under the PFS. Note that MedPAC's proposal would not affect the professional component or physician interpretation of the imaging service, only the facility fee paid to the hospital or hospital-based practice.

The impact of reducing HOPPS payments for cardiac imaging services affected by MedPAC's proposal would be substantial for cardiovascular medicine. For example, payment under HOPPS for a complete transthoracic echocardiographic study would fall by approximately 60%. In the wake of steep cuts in payment for cardiologic services under Medicare's PFS and the consequent integration of many practices with hospital systems, a larger proportion of cardiac imaging services are now being billed under HOPPS and will be affected by this policy. It is important to note that the effect of implementing site neutrality will not be a redistribution of payments within or between the HOPPS and the PFS but rather a net reduction in payments for cardiovascular imaging services.

Legislation would be required to implement MedPAC's recommendation, and no such legislation has yet been introduced or proposed. However, it is possible that Congress will look to a site-neutral payment policy as an offset for the cost of repealing or patching the sustainable growth rate before the temporary patch expires at the end of March 2015, and even further into the future.

The ACC has therefore adopted a set of principles for evaluating any proposals that may come forward. Specifically, the ACC's advocacy team will work to ensure that the following issues are addressed:

- Changes to Medicare payment should not harm access to care and quality of care, especially for vulnerable patient populations.
- Medicare payments should reflect the resources required to provide patient care in each setting: physician's office, hospital outpatient, and hospital inpatient. The "correct" payment may be different in different settings.
- Any payment differences across sites should be related to documented differences in the resources

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needed to ensure patient access and high-quality care. Some limits on payment differentials for the same service provided in different settings may be reasonable.

- Medicare payments for all sites of care should account for costs related to emergency capacity, compliance with regulatory requirements, geographic differences, quality improvement activities, and higher-need populations.
- Proposals to make significant changes to Medicare's payment systems (e.g., site-neutral payment proposals) should be carefully aligned with other rapid changes in health care, including the movement to value-based purchasing and alternative payment systems. Major changes should be implemented gradually to minimize any negative impact on patient access and quality.

At this critical time of fundamental change in the health care environment, it is imperative for all of us to remain positively engaged. The ACC and other societies must periodically distribute an RUC survey of new and existing services to establish and review work and practice expense RVUs. Your assistance with these surveys is critical to ensure that RVUs are accurately and fairly presented to CMS. CMS relies on recommendations from specialty societies and the RUC as a basis for setting payment levels for physician services. If you are randomly selected and receive a survey, please take the time to complete it. The information you provide in these surveys will be kept confidential by the ACC.

The Imaging Council, under its mandate from the Imaging Section, will continue to strive to maintain the relevance and vibrancy of the field.

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